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ABSTRACT

The multimodal therapy (MMT) approach provides a framework that facilitates systematic treatment selection in a broad-based, comprehensive and yet highly focused manner. It respects science, and data driven findings, and endeavors to use empirically supported methods when possible. Nevertheless, it recognizes that many issues still fall into the gray area in which artistry and subjective judgment are necessary, and tries to fill the void by offering methods that have strong clinical support. This paper provides a brief history of the MMT approach and methods of assessment and intervention. (Contains 26 references.) (GCP)

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Multimodal Therapy

by

Arnold A. Lazarus

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Multimodal Therapy

Arnold A. Lazarus, Ph.D.

The multimodal approach provides a framework that facilitates systematic treatment selection in a broad-based, comprehensive and yet highly focused manner. It respects science, and data driven findings, and endeavors to use empirically supported methods when possible. Nevertheless, it recognizes that many issues still fall into the gray area in which artistry and subjective judgement are necessary, and tries to fill the void by offering methods that have strong clinical support.

A Brief History of the MMT Approach

For several reasons, I became a strong advocate for behavior therapy (Wolpe & Lazarus, 1966), but after conducting careful outcome and follow-up inquiries, to my chagrin, I found that about one-third of my clients who had attained their therapeutic goals after receiving traditional behavior therapy tended to back slide or relapse. Further examination led to the obvious conclusion that the more people learn in therapy, the less likely they are to relapse. There is obviously a point of diminishing returns. In principle, one can never learn enough; there is always more knowledge and skills to acquire, but for practical purposes, an end point is imperative. So what are people best advised to learn so as to augment the likelihood of having minimal emotional problems?

Clearly there are essential behaviors to be acquired – acts and actions that are necessary for coping with life's demands. The control and expression of one's emotions are also imperative for adaptive living – it is important to correct inappropriate affective responses that undermine success in many spheres. Untoward sensations (e.g., the ravages of tension), intrusive images (e.g., pictures of personal failure and ridicule from others), and faulty cognitions (e.g., toxic ideas and irrational beliefs) also play a significant role in diminishing the quality of life. Each of the foregoing areas must be

addressed in an endeavor to remedy significant excesses and deficits. Moreover, the quality of one's interpersonal relationships is a key ingredient of happiness and success, and without the requisite social skills, one is likely to be cast aside, or even ostracized.

The aforementioned considerations led to the development of what I initially termed multimodal behavior therapy (Lazarus, 1973, 1976) which was soon changed to multimodal therapy (see Lazarus, 1981, 1986, 1997, 2000a, 2000b). Emphasis was placed on the fact that, at base, we are biological organisms (neurophysiological/biochemical entities) who behave (act and react), emote (experience affective responses), sense (respond to tactile, olfactory, gustatory, visual and auditory stimuli), imagine (conjure up sights, sounds and other events in our mind's eye), think (entertain beliefs, opinions, values and attitudes), and interact with one another (enjoy, tolerate, or suffer various interpersonal relationships). By referring to these seven discrete but interactive dimensions or modalities as **B**ehavior, **A**ffect, **S**ensation, **I**magery, **C**ognition, **I**nterpersonal, **D**rugs/Biologicals, the convenient acronym BASIC I.D. emerges from the first letter of each one.

The multimodal framework rests on a broad social and cognitive learning theory (e.g., Bandura, 1977, 1986; Rotter, 1954). The polar opposite of the multimodal approach is the Rogerian or Person-Centered orientation which is entirely conversational and virtually unimodal (see Bozarth, 1991). While, in general, the relationship between therapist and client is highly significant and sometimes "necessary and sufficient," in most instances, the doctor-patient relationship is but the soil that enables the techniques to take root. A good relationship, adequate rapport, a constructive working alliance are "usually necessary but often insufficient" (Fay & Lazarus, 1993; Lazarus & Lazarus, 1991a).

Many psychotherapeutic approaches are trimodal, addressing affect, behavior, and cognition – ABC. The multimodal approach provides clinicians with a comprehensive template. By separating sensations from emotions, distinguishing between images and

cognitions, emphasizing both intraindividual and interpersonal behaviors, and underscoring the biological substrate, the multimodal orientation is most far-reaching. By assessing a client's BASIC I.D. one endeavors to "leave no stone unturned."

Methods of Assessment and Intervention

The elements of a through assessment involve the following range of questions:

B: What is this individual doing that is getting in the way of his or her happiness of personal fulfillment (self-defeating actions, maladaptive behaviors)? What does the client need to increase and decrease? What should he/she stop doing and start doing?

A: What emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, combinations thereof, and to what extent (e.g., irritation versus rage; sadness versus profound melancholy)? What appears to generate these negative affects – certain cognitions, images, interpersonal conflicts? And how does the person respond (behave) when feeling a certain way? It is important to look for interactive processes – what impact does various behaviors have on the person's affect and vice versa? How does this influence each of the other modalities?

S: Are there specific sensory complaints (e.g., tension, chronic pain, tremors)? What feelings, thoughts and behaviors are connected to these negative sensations? What positive sensations (e.g., visual, auditory, tactile, olfactory and gustatory delights) does the person report? This includes the individual as a sensual and sexual being. When called for, the enhancement or cultivation of erotic pleasure is a viable therapeutic goal. (The importance of the specific senses, often glossed over or even by-passed by many clinical approaches, is spelled out by Ackerman, 1995).

I: What fantasies and images are predominant? What is the person's "self-image?" Are there specific success or failure images? Are there negative or intrusive images (e.g., flashbacks to unhappy or traumatic experiences)? And how are these images connected to ongoing cognitions, behaviors, affective reactions, and the like?

C: Can we determine the individual's main attitudes, values, beliefs and opinions? What are this person's predominant shoulds, oughts and musts? Are there any definite dysfunctional beliefs or irrational ideas? Can we detect any untoward automatic thoughts that undermine his or her functioning?

I.: Interpersonally, who are the significant others in this individual's life? What does he or she want, desire, expect and receive from them, and what does he or she, in turn, give to and do for them? What relationships give him/her particular pleasures and pains?

D.: Is this person biologically healthy and health conscious? Does he or she have any medical complaints or concerns? What relevant details pertain to diet, weight, sleep, exercise, alcohol and drug use?

The foregoing are some of the main issues that multimodal clinicians traverse while assessing the client's BASIC I.D. A more comprehensive problem identification sequence is derived from asking most clients to complete a Multimodal Life History Inventory (MLHI) (Lazarus & Lazarus, 1991b). This 15-page questionnaire facilitates treatment when conscientiously filled in by clients as a homework assignment, usually after the initial session. Seriously disturbed (e.g., deluded, deeply depressed, highly agitated) clients will obviously not be expected to comply, but most psychiatric outpatients who are reasonably literate, will find the exercise useful for speeding up routine history taking and readily provide the therapist with a BASIC I.D. analysis.

In addition, there are three other important assessment procedures employed in MMT – Second-Order BASIC I.D. Assessments, a method called Bridging and another called Tracking.

(1) <u>Second-Order BASIC I.D. Assessments</u>

If and when treatment impasses arise, a more detailed inquiry into associated behaviors, affective responses, sensory reactions, images, cognitions, interpersonal factors, and possible biological considerations may shed light on the situation. For

example, a client was making almost no progress with assertiveness training procedures. He was asked to picture himself as a truly assertive person and was then asked to recount how his behavior would differ in general, what affective reactions he might anticipate, and so forth across the BASIC I.D. This brought a central cognitive schema to light that had eluded all other avenues of inquiry: "I am not entitled to be happy." Therapy was then aimed directly at addressing this maladaptive cognition before assertiveness training was resumed.

(2) Bridging

Let's say a therapist is interested in a client's emotional responses to an event. "How did you feel when your father yelled at you in front of your friends?" Instead of discussing his feelings, the client responds with defensive and irrelevant intellectualizations. "My dad had strange priorities and even as a kid I used to question his judgment." It is often counterproductive to confront the client and point out that he is evading the question and seems reluctant to face his true feelings. In situations of this kind, *bridging* is usually effective. First, the therapist deliberately tunes into the client's preferred modality – in this case, the cognitive domain. Thus, the therapist explores the cognitive content. "So you see it as a consequence involving judgments and priorities. Please tell me more." In this way, after perhaps a 5-10 minute discourse, the therapist endeavors to branch off into other directions that seem more productive. "Tell me, while we have been discussing these matters, have you noticed any sensations anywhere in your body?" This sudden switch from Cognition to Sensation may begin to elicit more pertinent information (given the assumption that in this instance, Sensory inputs are probably less threatening than Affective material). The client may refer to some sensations of tension or bodily discomfort at which point the therapist may ask him to focus on them, often with an hypnotic overlay. "Will you please close your eyes, and now feel that neck tension. (Pause). Now relax deeply for a few moments, breathe easily and gently, in and out, in and out, just letting

yourself feel calm and peaceful." The feelings of tension, their associated images and cognitions may then be examined. One may then venture to bridge into Affect. "Beneath the sensations, can you find any strong feelings or emotions? Perhaps they are lurking in the background." At this juncture it is not unusual for clients to give voice to their feelings. "I am in touch with anger and with sadness." By starting *where the client is* and then bridging into a different modality, most clients then seem to be willing to traverse the more emotionally charged areas they had been avoiding.

(3) Tracking the Firing Order

A fairly reliable pattern may be discerned of the way that many people generate negative affect. Some dwell first on unpleasant sensations (palpitations, shortness of breath, tremors), followed by aversive images (pictures of disastrous events), to which they attach negative cognitions (ideas about catastrophic illness), leading to maladaptive behavior (withdrawal and avoidance). This S-I-C-B firing order (Sensation, Imagery, Cognition, Behavior) may require a different treatment strategy from that employed with say a C-I-S-B sequence, a I-C-B-S, or yet a different firing order. Clinical findings suggest that it is often best to apply treatment techniques in accordance with a client's specific chain reaction. A rapid way of determining someone's firing order is to have him or her in an altered state of consciousness – deeply relaxed with eyes closed – contemplating untoward events and then describing their reactions.

A Structural Profile Inventory (SPI) has been developed and tested. This 35-item survey provides a quantitative rating of the extent to which clients favor specific BASIC I.D. areas. The instrument measures action-oriented proclivities (Behavior), the degree of emotionality (Affect), the value attached to various sensory experiences (Sensation), the amount of time devoted to fantasy, day dreaming, and "thinking in pictures" (Imagery), analytical and problem solving propensities (Cognition), the importance attached to interacting with other people (Interpersonal),

and the extent to which health-conscious habits are observed (Drugs/Biology). (Drugs/Biology). The reliability and validity of this instrument has been borne out by research (Herman, 1992; Landes, 1991). Herman (1991, 1994, 1998) showed that when clients and therapists have wide differences on the SPI, therapeutic outcomes tend to be adversely affected.

In multimodal assessment, the BASIC I.D. serves as a template to remind therapists to examine each of the seven modalities and their interactive effects. It implies that we are social beings who move, feel, sense, imagine and think, and that at base we are biochemical-neurophysiological entities. Students and colleagues frequently inquire whether any particular areas are more significant, more heavily weighted, than the others. For thoroughness, all seven require careful attention, but perhaps the biological and interpersonal modalities are especially significant.

The Biological Modality wields a profound influence on all the other modalities. Unpleasant sensory reactions can signal a host of medical illnesses; excessive emotional reactions (anxiety, depression and rage) may all have biological determinants; faulty thinking, and images of gloom, doom and terror may derive entirely from chemical imbalances; and untoward personal and interpersonal behaviors may stem from many somatic reactions ranging from toxins (e.g., drugs or alcohol) to intracranial lesions. Hence, when any doubts arise about the probable involvement of biological factors, it is imperative to have them fully investigated. A person who has no untoward medical/physical problems and enjoys warm, meaningful and loving relationships, is apt to find life personally and interpersonally fulfilling. Hence the biological modality serves as the base and the interpersonal modality is perhaps the apex. The seven modalities are by no means static or linear but exist in a state of reciprocal transaction.

A question often raised is whether a "spiritual" dimension should be added. In the interests of parsimony, I point out that when someone refers to having had a "spiritual" or a "transcendental" experience, typically their reactions point to, and can be captured by, the interplay among powerful cognitions, images, sensations and affective responses.

Multimodal therapists carefully note the specific modalities across the BASIC I.D. that are being discussed, and which ones are omitted or glossed over. The latter (i.e., the areas that are overlooked or neglected) often yield important data when specific elaborations are requested. And when examining a particular issue, the BASIC I.D. will be fairly rapidly but nevertheless carefully traversed.

There is a lot more to the multimodal methods of inquiry and treatment and the interested reader is referred to some of my other publications that spell out the details (e.g., Lazarus, 1989, 1997, 2000a). In general, it seems to me that narrow school adherents are receding into the minority and that competent clinicians are all broadening their base of operations. The BASIC I.D. spectrum has continued to serve as a most expedient template or compass.

Follow-up studies that have been conducted since 1973 have consistently suggested that durable outcomes are in direct proportion to the number of modalities deliberately traversed. Although there is obviously a point of diminishing returns, it is a multimodal maxim that the more someone learns in therapy, the less likely he or she is to relapse. In this connection, circa 1970, it became apparent that lacunae or gaps in people's coping responses were responsible for many relapses. This occurred even after they had been in various (non-multimodal) therapies, often for years on end. Follow-ups indicate that this ensures far more compelling and durable results (Lazarus, 2000a). MMT takes Paul's (1967) mandate very seriously: "What

treatment, by whom, is most effective for this individual with that specific problem and under which set of circumstances? "(p. 111).

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